

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01345					01303				
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON 05-2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>NARCISSA LEE ADAMS</u>			4. DATE OF DEATH <u>JAN. 16 1966</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCT 30, 1889</u> 9. AGE (in years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE NEIGHBORS</u>			14. MOTHER'S MAIDEN NAME <u>VERGINIA BECK</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS VIRGINIA RASH, DENTON, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1-9-66</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert W. Trever</u>					22b. DATE SIGNED <u>1/16/66</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>			M.D. <u>M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>			1/16/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 18, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		23d. LOCATION (City, town or county) (State) <u>Caroline Co. Md.</u>			
24. FUNERAL DIRECTOR <u>J. V. Moore Denton</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01346		01304									
1. PLACE OF DEATH a. COUNTY <i>TALBOT</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>EASTON</i> c. LENGTH OF STAY IN 1b <i>18</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>MEMORIAL HOSPITAL</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CAROLINE</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>DENTON</i> d. STREET ADDRESS <i>05-2</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>GRACE</i> Middle <i>L.</i> Last <i>BOWDLE</i>				4. DATE OF DEATH Month <i>1</i> Day <i>27</i> Year <i>1966</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/29, 1880</i>		9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>WILLIAM H. MEREDITH</i>						14. MOTHER'S MAIDEN NAME <i>SARAH SMITH</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. JOSEPH HARRINGTON, DENTON</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage with left</i> <i>331X</i> DUE TO (b) <i>hemiplegia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>19 Jan</i> , 19 <i>66</i> , to <i>27 Jan</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>27 Jan</i> , 19 <i>66</i> , and that death occurred at <i>7:30</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Arthur Harrison</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>28 Jan 66</i>			
22c. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>						22d. ADDRESS <i>EASTON, MARYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>FEB. 1, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DENTON</i>		23d. LOCATION (City, town or county) (State) <i>DENTON MD.</i>					
24. FUNERAL DIRECTOR <i>J. Vergil Moore & Son</i>				ADDRESS <i>Denton 24</i>		25a. REC'D BY REGISTRAR <i>Feb 2 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01347 CERTIFICATE OF DEATH 01305									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>					c. LENGTH OF STAY IN 1b <u>4 1/2 hr.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>Near Elwood</u>				
3. NAME OF DECEASED (Type or print) <u>Angel</u> First <u>Mario</u> Middle <u>Briggs</u> Last					4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1965</u>		9. AGE (In years last birthday) yrs. <u>6</u> Months <u>1</u> Days <u>1</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Easton, Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Luis Chanza</u>					14. MOTHER'S MAIDEN NAME <u>Virginia Briggs</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Virginia Briggs, Hurlock, Maryland, RFD</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 493x DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN DNST AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>William H. Hargfield</u>					22b. DATE SIGNED <u>1/14/66</u>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Jan. 17, 1966</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Near Hurlock, Maryland</u>				
24. FUNERAL DIRECTOR <u>William Hargfield</u>					25a. REC'D BY REGISTRAR <u>18 JAN 1966</u>				
ADDRESS <u>Frederick, Maryland</u>					25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>				

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Memorial Hospital
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20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN 1b <u>6:50 pm - 8 pm</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> <u>20-1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>					d. STREET ADDRESS <u>703 S. HANSON</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER Finley COMEGYS</u>			4. DATE OF DEATH Month Day Year <u>1</u> <u>5</u> <u>1966</u>								
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 4, 1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>INTERIOR DECORATOR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE M.D.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES COMEGYS</u>			14. MOTHER'S MAIDEN NAME <u>SUSAN HASSETT</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-09-5087</u>		17. INFORMANT <u>Mrs. W. F. Duggins</u> <u>703 S. Hanson St. Easton Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1 July</u> , 19 <u>65</u> , to <u>3 June</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5 June</u> 19 <u>66</u> , and that death occurred at <u>8 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Thorston Harrison</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. ADDRESS <u>Easton Maryland</u>		22b. DATE SIGNED <u>7 June 66</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 8, 66</u>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial</u>		23d. LOCATION (City, town or county) (State) <u>At 506 Easton Md</u>				
24. FUNERAL DIRECTOR <u>Edith Clark</u>			ADDRESS <u>Easton Md</u>		25a. REC'D BY REGISTRAR <u>JAN 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>				

11300

CERTIFICATE OF DEED

Know all men that I, the undersigned, of the County of [illegible] State of [illegible], for and in consideration of the sum of [illegible] Dollars, to [illegible] in hand paid by [illegible], the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said [illegible] of the County of [illegible] State of [illegible], all that certain [illegible] of land, situate in the County of [illegible] State of [illegible], containing [illegible] acres, more or less, as the same may appear by the [illegible] and [illegible] of record in the office of the County Clerk of the County of [illegible] State of [illegible], to have and to hold unto the said [illegible] his heirs and assigns forever.

Witness my hand and seal this [illegible] day of [illegible] 19[illegible]

Given under my hand and seal of office at the City of [illegible] State of [illegible] this [illegible] day of [illegible] 19[illegible]

Notary Public for the State of [illegible]

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MEDICAL CERTIFICATION

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01349 01307											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>						c. LENGTH OF STAY IN 1b <u>Life</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Elbert</u> Last <u>Cooper</u>						4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 4, 1906</u>		9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY COOPER</u>						14. MOTHER'S MAIDEN NAME <u>HENRIETTA PRICE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>EASTON HOSPITAL RECORDS</u> Address <u>EASTON, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271 Congestive heart failure</u> DUE TO (b) <u>Lobar pneumonia</u> DUE TO (c) <u>cor pulmonale and chronic pulmonary emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>Several years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1963</u> to <u>4-Jan, 1966</u> , that (I) (we) last saw the deceased alive on <u>4-Jan - 1966</u> , and that death occurred at <u>4:50 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Dale R. Kollman</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4-Jan-1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u>						22d. ADDRESS <u>12 N. Hanson St.; Easton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DUNFORD NECK CEM.</u>				23d. LOCATION (City, town or county) (State) <u>Oxford Md.</u>			
24. FUNERAL DIRECTOR <u>James B. Daskrell</u>						25a. REC'D BY REGISTRAR <u>Jan 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01350											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>12 hrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton 20-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS <u>315 South St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Perry</u> Middle <u>Albert</u> Last <u>Copper</u>				4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-20</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Copper</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Wright</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>NW 11</u>				16. SOCIAL SECURITY NO. <u>218-03-7951</u>				17. INFORMANT <u>Harriet Copper</u> Address <u>Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO (b) <u>Bronchogenic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1621</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1966</u> to <u>Jan. 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 20, 1966</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dale R Kollman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>20-Jan-1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>D. Kollman, M.D.</u>				22d. ADDRESS <u>Easton, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>			
24. FUNERAL DIRECTOR <u>James B Dashieff</u>				ADDRESS <u>Easton Md</u>				25a. REC'D BY REGISTRAR <u>Jan 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>	

Brucella abortus
Pulmonary hemorrhage
10 min. 5 min.

X

Jan. 20 1911
B. R. Johnson
Jan. 20 1911
B. R. Johnson
Jan. 20 1911
B. R. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
01351		01309									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>43 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Graisonville</u> <u>17-2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Eddie</u> Middle <u>Cullison</u> Last						4. DATE OF DEATH Month <u>1/</u> Day <u>24</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1901</u>		9. AGE (in years last birthday) <u>64</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster shucker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Cullison</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-38-924</u>		17. INFORMANT Address <u>Mrs. Mary Christian - Graisonville</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Status</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>6 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u>, 19<u>66</u>, to <u>1/24</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>1/24</u>, 19<u>66</u>, and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>C. R. Layton</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-27-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>						22d. ADDRESS <u>Centreville Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN. 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Chester Maryland</u>			
24. FUNERAL DIRECTOR <u>James H. Butler</u>						ADDRESS <u>Butler Bros. Centerville, Maryland</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>James H. Judge</u>	
						DATE <u>FEB 1 1966</u>					

01500

01500

Marshall

Marshall

1/14/62

Marshall

Robert Callison

Marshall

Marshall

Marshall

Marshall

Marshall

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Marshall

Marshall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01352		01310									
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>27 days / 6 1/2 hrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>						d. STREET ADDRESS <i>Jack's Point</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sarah Catherine Dobson</i>						4. DATE OF DEATH Month <i>Jan</i> Day <i>7</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/23/1880</i>		9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i> Hours <i>66</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>B. Harrison Baynard</i>						14. MOTHER'S MAIDEN NAME <i>Mary Neighbors</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>unkn.</i>		17. INFORMANT <i>Walter H. Dobson, St. Michaels, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> <i>1533</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of sigmoid colon</i> DUE TO (c) <i>1533</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>12-9</i> , 19 <i>65</i> , to <i>1-7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1-7</i> , 19 <i>66</i> , and that death occurred at <i>7:57</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>K. Lane Wroth</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>1-8-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>K. LANE WROTH</i>						22d. ADDRESS <i>St. Michaels, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1/11/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Oxford, Md.</i>		
24. FUNERAL DIRECTOR <i>Maurice E. Newman</i>						ADDRESS <i>Easton, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JAN 12 1966</i>											

11/13/10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01353						02841					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Talbot			EASTON			Maryland			CAROLINE		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
10 days			MEMORIAL HOSPITAL			Denton RFD			Box 186		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			6. IS RESIDENCE ON A FARM?		
First Middle Last						Date Month Day Year			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
LILLIE DVER						1 29 19 66					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		C				JULY 15, 1893		72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Domestic				Retired		Maryland				USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Frank Sattlefield						Pricella Baynard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
						LYDA Green, Denton, md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Ventricular fibrillation											
4201 DUE TO (b) Coronary insufficiency											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerotic heart disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 6:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE R. Trever											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR ADDRESS											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
James B. Daskin / Easton md											
FEB 10 1966											
felcharles judge											

1889

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01354											
01311											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston</u> <u>05-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>First</u> <u>BABY</u> <u>Middle</u> <u>BOY</u> <u>Last</u> <u>DYOTT</u>						4. DATE OF DEATH <u>Month</u> <u>January</u> <u>Day</u> <u>6</u> <u>Year</u> <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 15, 1966</u>		9. AGE (In years last birthday) <u>Yrs.</u> <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
13. FATHER'S NAME <u>SAMUEL DYOTT</u>						14. MOTHER'S MAIDEN NAME <u>CYNTHIA BISHOFF</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>SAMUEL DYOTT</u> Address <u>PRESTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>30 weeks gestation</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>30 weeks gestation</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5,</u> 19 <u>66</u> , to <u>Jan 6,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6</u> 19 <u>66</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>H. R. Tappnell</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1.9.66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. R. Tappnell, M.D.</u>						22d. ADDRESS <u>Federalburg, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>JAN 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City, town or county) <u>EASTON, MD.</u>		(State)			
24. FUNERAL DIRECTOR <u>J. Virgil Moore & Son</u> ADDRESS <u>Penton Md</u>						25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			
DATE <u>JAN 13 1966</u>											

6-160792

THE BOARD OF HEALTH
CITY OF NEW YORK
1910

MEMORANDUM
TO THE BOARD OF HEALTH
FROM THE BOARD OF HEALTH
SUBJECT: [illegible]

RESOLVED, THAT [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Board of Health, this [illegible] day of [illegible] 1910.

JOHN J. [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01355					01312				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <i>Talbot</i>					a. STATE <i>Maryland</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>					b. COUNTY <i>Talbot</i>				
c. LENGTH OF STAY IN 1b <i>9 mo.</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <i>Martha Pier</i> Middle <i>Easterbrook</i> Last					Month <i>1/15</i> Day <i>19</i> Year <i>66</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/4/1886</i>		9. AGE (In years last birthday) <i>79</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <i>Edward J. Carpenter</i>					14. MOTHER'S MAIDEN NAME <i>Martha Pier</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>074-18-0051</i>		17. INFORMANT <i>Mrs. Thelma E. Howell, Beachwood, N.J.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Occlusion</i>									<i>4 d.</i>
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis, generalized</i>									<i>Yrs</i>
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Dec</i> , 19 <i>65</i> , to <i>1/15</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>Jan 1</i> , 19 <i>66</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>S. Kreck</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-17-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>S. Kreck, Jr.</i>					22d. ADDRESS <i>Easton, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>1/17/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>MURPHY C. NEWMAN & SON, Easton, Md.</i>					25a. REC'D BY REGISTRAR <i>AN 18 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
01356					CERTIFICATE OF DEATH					01313														
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					c. LENGTH OF STAY IN 1b <u>14 da</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> <u>05-2</u>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>None</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>Dorothy DEAN Fountain</u>					4. DATE OF DEATH <u>1</u> <u>12</u> <u>1966</u>																			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-1-1904</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Harvey H. Dean</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Boyle</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>169-18-1311</u>					17. INFORMANT <u>Jayne Parncutt Boothwyn, Pa.</u> Address														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCITIES, ANEMIA.</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF THE STOMACH</u> DUE TO (c) <u>3 MD</u>										INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-12</u> 19 <u>66</u> , and that death occurred at <u>1p</u> M, from the causes and on the date stated above.																								
22a. SIGNATURE <u>H. M. Walsh</u> M.D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>1/14/66</u>									
22c. PHYSICIAN'S NAME (Type) <u>H. M. Walsh</u>										22d. ADDRESS <u>M. D. Easton, Maryland</u>					1/14/66									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>1-16-66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>					23d. LOCATION (City, town or county) (State) <u>Denton, Maryland</u>									
24. FUNERAL DIRECTOR <u>J. E. Boulaiv Greensboro, Md.</u> ADDRESS										25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> DATE <u>JAN 17 1966</u>					25b. REGISTRAR'S SIGNATURE									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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102P

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01357					01314				
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>23 day - 5 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital Easton</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak (rural)</u> d. STREET ADDRESS <u>20-1</u>				
3. NAME OF DECEASED (Type or print) <u>Fanny Ellington Shreleaf</u> First <u>Fanny</u> Middle <u>Ellington</u> Last <u>Shreleaf</u>					4. DATE OF DEATH Date <u>Jan 1</u> 19 <u>66</u> Month <u>Jan</u> Day <u>1</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13 1906</u> yrs. <u>57</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min. <u>57</u>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Case Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Welfare Board</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James E. Ellington</u>					14. MOTHER'S MAIDEN NAME <u>Mattie Morrison</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-12-4765</u>		17. INFORMANT <u>William S. Denny, Easton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> <u>5810</u> DUE TO <u>liver failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>cirrhosis of the liver</u> (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>3 mos</u> <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u> </u> , to <u>1-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 1</u> , 19 <u>66</u> , and that death occurred at <u>5:18</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Wm Reeser</u> M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>1-3-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm Reeser</u>						22d. ADDRESS <u>St Michaels Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>			
24. FUNERAL DIRECTOR <u>Maurice A. Neuman-Son</u> ADDRESS <u>Easton, Md</u>						25a. REC'D BY REGISTRAR <u>Jan 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01358

01315

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wittman c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wittman d. STREET ADDRESS 20-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY HESTER HADDAWAY		4. DATE OF DEATH Month January Day 9 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29, 1898 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Talbot County, Md.
13. FATHER'S NAME James H. Fairbank		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-16 8825	17. INFORMANT Ella Kerper Address Mitchell H. Haddaway, Wittman, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO coronary occlusions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO atherosclerotic coronary airt d PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-9-66 to 1-11-66 , that (I) (we) last saw the deceased alive on 11-30-1965 , and that death occurred at 2:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE Guy M. Reeser, Jr. M.D.		22b. DATE SIGNED 1-11-66	
22c. PHYSICIAN'S NAME (Type) GUY M. REESER, Jr., M. D.		22d. ADDRESS St. Michaels, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 12, 1966	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City, town or county) (State) Easton, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Hampton Harrison ADDRESS St. Michaels		25a. REC'D BY REGISTRAR JAN 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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Widow

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Widow

January 2, 1966

RECEIVED

Sept 29, 1966

Tablet

USA

Tablet County, Md.

Housewife

John Kasper

James H. Kasper

Michael H. Kasper, Widow, Maryland

BUYER'S ADDRESS, J. D. 82, Nichols, Maryland

BUYER'S ADDRESS, J. D. 82, Nichols, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01359 02848											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY in 1b <u>88 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u> d. STREET ADDRESS <u>17-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BERNADETTE MARIE Harding</u> First Middle Last						4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 30, 1966</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>28</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard LEE Harding</u>						14. MOTHER'S MAIDEN NAME <u>LOUISE MARIE MAGROGAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Richard LEE Harding, QUEENSTOWN, Md.</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>7625</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PREMATURE RUPTURE OF MEMBRANES</u> INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>John A. Hawkinson M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-3-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John A. Hawkinson, M.D.</u>						22d. ADDRESS <u>Easton, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>FEB. 1, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>QUEENSTOWN, Maryland</u>			
24. FUNERAL DIRECTOR <u>James H. Butler Jr., Baltimore, Md.</u>						24a. REC'D BY REGISTRAR <u>5 FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6-160702

48280

James
Wm. Davidson

Carroll County, Md.
1890
I have been thinking of writing you
for some time but have been too busy
to do so.

AN OXIA
PREMATURE

PREMATURE
OF MEMBERS

John Davidson
2-3-66

John Davidson
2-3-66

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN b 3 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines - Easton		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL EASTON d. STREET ADDRESS Rt. #3 - Bx 95 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Walter Hopkins First Middle Last 4. DATE OF DEATH Jan. 21 1966 Month Day Year		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-9-1887 9. AGE (in years last birthday) 78 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 10b. KIND OF BUSINESS OR INDUSTRY FARMER 11. BIRTHPLACE (County & State, or foreign country) TALBOT 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JAMES W. HOPKINS		14. MOTHER'S MAIDEN NAME MARY EMILY HINSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 16. SOCIAL SECURITY NO. 717-36-1468		17. INFORMANT WILLIAM H. HOPKINS Address 316 Belvidere Ave Cambridge Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Central thrombosis & (R) hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 332X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 23 May 1963 to 21 Jan 1966 , that (I) (we) last saw the deceased alive on 21 Jan 1966 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Thorston Harrison		22b. DATE SIGNED 22 Jan 66	
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF JAN 25, 66	
23c. NAME OF CEMETERY OR CREMATORY SPRING HILL		23d. LOCATION (City, town or county) (State) EASTON MD	
24. FUNERAL DIRECTOR Willie Lat		25a. REC'D BY REGISTRAR Jan 25 1966 25b. REGISTRAR'S SIGNATURE John Charles Judge	

01316

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01316

House in the first - Boston

House in the first - Boston

Jan. 21

House in the first - Boston

House in the first - Boston

House in the first - Boston

House in the first - Boston

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove (detach) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01361

01317

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>St. Michaels</u> <u>Md.</u> <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels Md.</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Records Riv Vista Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>210 Goldsborough St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Helen</u> Last <u>Imbody</u> 4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1966</u> 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 13 - 1894</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 13. FATHER'S NAME <u>John Mc. Hurk</u> 14. MOTHER'S MAIDEN NAME <u>Caroline Du Bois</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Records Riv Vista Nursing Home</u> Address <u> </u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection</u> <u>1750</u> DUE TO <u>Carcinomatous ovarion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1962</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> <u>Body willied to anatomy hood Md.</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>63</u> to <u>1/6/66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1/1</u> , 1966, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.				22a. SIGNATURE <u>J.T.B. Ambler</u> M.D. 22b. DATE SIGNED <u>1/6/66</u> 22c. PHYSICIAN'S NAME (Type) <u>J.T.B. AMBLER</u> 22d. ADDRESS <u>Box 1025 Easton Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> 23b. DATE THEREOF <u>1/7/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md.</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Hamilton Harrison, St. Michaels Md.</u> 25a. REC'D BY REGISTRAR <u>Charles J. J...</u> 25b. REGISTRAR'S SIGNATURE <u> </u> DATE <u>JAN 10 1966</u>			

0390

01310

01380

John

Kind the last thing I hear

Constitution

Children help with to out of world

March 17/10

2 to 1000

Box 1000 Eastern

Constitution 1000 1000 1000

781
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md b. COUNTY Q.A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) QUEENSTOWN	
c. LENGTH OF STAY IN 1D 1 hr 25 min		d. STREET ADDRESS Rt 2 I	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Wm Last JR		4. DATE OF DEATH Month 1 Day 10 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/1902
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET Md GAMBL COMM		10b. KIND OF BUSINESS OR INDUSTRY COMM	
11. BIRTHPLACE (State or foreign country) KENT CO Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES WM IVENS SR		14. MOTHER'S MAIDEN NAME ELLEN J PORTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-36-2087	
17. INFORMANT Mrs. Daisy Ivens		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of 976X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. OUE TO (b) Centre forehead OUE TO (c) 3 hours		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted Gun shot	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:45 p.m. 1-10 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Wye Mills (County) Q.A (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. R. Layton		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) C. R. Layton		Address (Street, city, town, or county) Centreville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 13, 1966	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.	
25a. REC'D BY REGISTRAR JAN 12 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01318

11802

8 Mrs Daisy Evans
Guest at board of
Center for hand

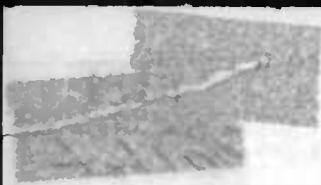
Self Inflicted Gun shot

W. R. Taylor
1-10-14

1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01363		01319	
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	
c. LENGTH OF STAY IN 1b <i>life</i>		d. STREET ADDRESS <i>21 Higgins St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>21 Higgins St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Thomas</i> Last <i>Johnson</i>		4. DATE OF DEATH Month <i>JAN</i> Day <i>15</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 2, 1885</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Talbot, Md.</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>William Thomas</i>	
14. MOTHER'S MAIDEN NAME <i>Anne Sherwood</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sarah Pritchett</i> Address <i>Easton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> <i>443 X</i> DUE TO (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>Generalized Atherosclerosis</i> Uremia			INTERVAL BETWEEN ONSET AND DEATH <i>1 Mo.</i> <i>years</i> <i>months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 12</i> , 19 <i>65</i> , to <i>Jan 16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 14</i> , 19 <i>66</i> , and that death occurred at <i>8:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard F. Tyson</i>		22b. DATE SIGNED <i>1-17-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Richard F. Tyson M.D.</i>		22d. ADDRESS <i>36 South Aurora St. Easton, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>1-19-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Richards Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Easton, Md.</i>
24. FUNERAL DIRECTOR <i>James F. Vashell</i>		25a. REC'D BY REGISTRAR <i>James F. Vashell</i>	
25b. REGISTRAR'S SIGNATURE <i>James F. Vashell</i>		DATE <i>FEB 1 1966</i>	



UNITED STATES OF AMERICA

1136

1136

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

1136

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UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01364

01320

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First RUTH Middle B Last JOHNSON		4. DATE OF DEATH		Month 1 Day 6 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/07	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 5 Days 8	IF UNDER 24 HRS. Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY TYPEIST		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUSSELL BELL				14. MOTHER'S MAIDEN NAME FLORENCE WEBER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT WILMER JOHNSON, DENTON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion of the heart 170X DUE TO Bone & liver metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 8:55 M, from the causes and on the date stated above.							
22a. SIGNATURE Arthur B. Cecil, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Arthur B. Cecil, Jr. M.D.				22d. ADDRESS Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF JAN. 10, 1966		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City, town or county) (State) DENTON MD	
24. FUNERAL DIRECTOR L. V. MOORE DENTON				25a. REC'D BY REGISTRAR JAN 11 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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01116

RECEIVED
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items #8 & 9 Film #0372 2/11/66											
01365 02854											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>						c. LENGTH OF STAY IN 1b MARYLAND					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>24 Higgins St.</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						d. STREET ADDRESS <u>24 Higgins St.</u>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>ARTHUR</u> Last <u>JOHNSON</u>						4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Ne GRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 28 1881</u>		9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during month of death, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Caroline Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Robert Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Julia A. Foster</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO <u>MYXEDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>13 July, 1965</u> to <u>31 JAN, 1966</u> , that (2) (we) last saw the deceased alive on <u>31 JAN 1966</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard F. Tyson</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2 Feb 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD F. TYSON</u>						22d. ADDRESS <u>36 AURORA ST. EASTON Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RICHARDS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>EASTON MARYLAND</u>			
24. FUNERAL DIRECTOR <u>James B. Marshall</u>						ADDRESS <u>Easton Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01366									
01321									
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			c. LENGTH OF STAY IN 1b 22 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg 05-2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida First Victoria Middle Jones Last			4. DATE OF DEATH 1 9 1966						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1883		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Wesley Nichols					14. MOTHER'S MAIDEN NAME Henrietta Rideout				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-20-5052		17. INFORMANT Winnie Nichols, Federalsburg, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 18 Dec , 19 65 , to 9 Jan , 19 66 , that (I) (we) last saw the deceased alive on 8 Jan , 19 66 , and that death occurred at 10 AM , from the causes and on the date stated above.									
22a. SIGNATURE Stephen P. Garney M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-11-66		
22c. PHYSICIAN'S NAME (Type) Stephen P. Garney M.D.					22d. ADDRESS Easton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1966		23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery			23d. LOCATION (City, town or county) (State) Near Hurlock, Maryland		
24. FUNERAL DIRECTOR J. J. Hampton & Son ADDRESS Federalsburg, Md.					25a. REC'D BY REGISTRAR JAN 18 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

1951

1951

Robert Johnson
Robert Johnson

Robert Johnson

1-11-55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01367

01322

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House of the Pines Nursing Home.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Cape May c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ocean City d. STREET ADDRESS 405 E. 23 rd St; e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James S. Leaming		4. DATE OF DEATH Jan. 29 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/73
9. AGE (In years last birthday) 92 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mechanical Dentist	11. BIRTHPLACE (County & State, or foreign country) Greenwich N.J.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Donovan R. Leaming, Oxford, Md.	
17. INFORMANT Donovan R. Leaming, Oxford, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cancer of the rectum			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 hours MALE Yes.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1 Dec 1965 to 29 Jan 1966 , that (I) (we) last saw the deceased alive on 29 Jan 1966 , and that death occurred at 6:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Stephen Carney		22b. DATE SIGNED 1-29-66	
22c. PHYSICIAN'S NAME (Type) Stephen Carney, M.D.		22d. ADDRESS Easton, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Feb. 2, 1966	23c. NAME OF CEMETERY OR CREMATORY Overlook Cemetery	23d. LOCATION (City, town or county) (State) Bridgeton, N.J.
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fallow Millington Inf.		25a. REC'D BY REGISTRAR FEB 4 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1933

CERTIFICATE OF DEATH

1933



[Faint, mostly illegible text from a death certificate form, including fields for name, date, and location.]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01368		01323	
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dutchman's Lane</i>		d. STREET ADDRESS <i>Dutchman's Lane</i>	
3. NAME OF DECEASED (Type or print) First <i>Lulu May</i> Middle <i>Marvel</i> Last <i>Marvel</i>		4. DATE OF DEATH Month <i>1/5/</i> Day <i>166</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/28/1888</i>
9. AGE (In years last birthday) <i>77</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert James</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Griffin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>161-16-3914 A</i>	
17. INFORMANT <i>Raymond Marvel, Easton, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pulmonary embolism</i> <i>465x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Metastatic neoplasm</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>65</i> , to <i>1-5</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>1-5</i> 19 <i>66</i> , and that death occurred at <i>5 PM</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trever</i>		22b. DATE SIGNED <i>1-7-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		22d. ADDRESS <i>R D 3 Easton, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/8/1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City, town or county) (State) <i>Easton, Md.</i>	
24. FUNERAL DIRECTOR <i>MURPHY E. NEUNAM & SON, Easton, Md.</i>		25a. REC'D BY REGISTRAR <i>12 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

Tablet

Tablet

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Case on

Case on

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Leitchman's Lane

Leitchman's Lane

12/25/1952
XX 77

Female white

Tablet (unlabeled)

Tablet (unlabeled)

Robert Griffin

Robert Griffin

10-15-54, Raymond Street, Boston, MA.

no

Robert Griffin

Robert Griffin

Robert Griffin

Robert Griffin

Robert Griffin, 10-15-54, Raymond Street, Boston, MA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01369

01324

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>			
c. LENGTH OF STAY IN 1b <u>18 days</u>				d. STREET ADDRESS <u>Denton Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>EDNA</u> Last <u>MERRICK</u>				4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/7/89</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Spring Prairie, Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Ward</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Starkey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>E. Russell Merrick, Federalsburg, Md., RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiratory pneumonia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-intestinal hemorrhage</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-29-</u> 19 <u>65</u> , to <u>1-16-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-16-</u> 19 <u>66</u> , and that death occurred at <u>7:16</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>				22d. ADDRESS <u>M.D. Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son</u>				ADDRESS <u>Federalsburg</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
				DATE <u>JAN 24 1966</u>		25b. REGISTRAR'S SIGNATURE	

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2025 COLLECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01370		Item #2 infor. taken from birth cert.				01325				
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>7 Judas St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>(A) Baby Girl Messick</u>		Middle		Last		4. DATE OF DEATH		Month Day Year <u>1 30 1966</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/29/1966</u>		9. AGE (In years last birthday) <u>10</u> IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Messick</u>					14. MOTHER'S MAIDEN NAME <u>Joan Harrison</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>James M. Messick, St. Michaels, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>66</u> , to <u>1-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-30</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>Lucy M. Reeser</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-2-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lucy M. Reeser</u>					22d. ADDRESS <u>St. Michaels Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/2/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>			
24. FUNERAL DIRECTOR <u>Maurice K. Newman</u> ADDRESS <u>Easton, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>FEB 7 1966</u>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
<div style="display: flex; justify-content: space-between;"> 013271 Item #2 Infor. taken from birth certificate 01326 </div>											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS <u>7 Judas St.</u>					
3. NAME OF DECEASED (Type or print) <u>(B) BABY LYNN</u> Middle						4. DATE OF DEATH Last <u>Messick</u> Month <u>1</u> Day <u>30</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/29/1966</u>		9. AGE (In years last birthday) <u>9</u> yrs. <div style="display: flex;"> <div>IF UNDER 1 YEAR</div> <div>IF UNDER 24 HRS.</div> </div>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Messick</u>						14. MOTHER'S MAIDEN NAME <u>Joan Harrison</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>James M. Messick, St. Michaels, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="flex: 1;"> INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u> </div> </div>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>66</u> , to <u>1-30</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>1-30</u> , 19 <u>66</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Ray M. Reese</u>						22b. DATE SIGNED <u>2-2-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Ray M. Reese</u>		22d. ADDRESS <u>St. Michaels Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/2/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		
24. FUNERAL DIRECTOR <u>Manuel A. Karamos</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Easton, Md</u>		25d. ADDRESS <u>6 - 160704</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxford		c. LENGTH OF STAY IN 1b 47 years		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elizabeth V. Neunam			First Middle Last			4. DATE OF DEATH Day 1/19 Year 1966					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/1876		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel R. Valliant						14. MOTHER'S MAIDEN NAME Sarah Leonard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Sara V. Benson, Oxford, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary atherosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Circumstances of the pancreas											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July , 19 46 , to 19 Jan , 19 66 , that (I) (we) last saw the deceased alive on 18 Jan , 19 66 , and that death occurred at 9 P M, from the causes and on the date stated above.											
22a. SIGNATURE Thorston Harrison						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20 Jan 66			
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON						22d. ADDRESS Easton, Maryland 21001					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/1966		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town or county) (State) Easton, Md.					
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md.						25a. REC'D BY REGISTRAR DATE JAN 24 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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01328

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in 1b <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>Harlock</u> <u>09-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Glen</u> Middle <u>Marion</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/1911</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming - Road Grading</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grading</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Irving Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Lena Grupe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>000-00-0000</u>	
17. INFORMANT <u>Mrs Doris Palmer, Harlock, Md</u>		Address <u>Harlock, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of head of 157X</u> DUE TO (b) <u>Painkillers</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE SIGNED <u>29 Jan 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town or county) (State) <u>East New Market, Md</u>	
24. FUNERAL DIRECTOR <u> </u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>FEB 3 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~throw~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					01329				
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels (rural)</u>			c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rio Vista Nursing Home</u>					d. STREET ADDRESS <u>381 Glebe Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Pritchard</u>			First Middle Last		4. DATE OF DEATH <u>1/23</u> 19 <u>66</u>		Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/22 1877</u>		9. AGE (In years last birthday) <u>88</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Kirkman</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Saulsbury</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>218-01-8629</u>		17. INFORMANT <u>Mrs. James Allen, Jr., Easton, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Symptoms of Left V. Rec.</u> 4501 DUE TO (b) <u>Chloroform Anesthesia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Byr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3 Dec</u> , 19 <u>65</u> to <u>23 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>22 Jan</u> , 19 <u>66</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Rene C. Watts</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-26-66</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/26/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>		
24. FUNERAL DIRECTOR <u>MAURICE E. NEWMAN & SON, Easton, Md.</u>					25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
01375					01330							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY <u>Talbot</u>					a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
<u>Easton</u>					<u>GRASONVILLE</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS							
<u>Memorial Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year			
<u>William</u>			<u>James</u>			<u>Rada</u>			<u>JAN. - 5 - 19 66</u>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>MALE</u>		<u>WHITE</u>		<u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<u>SEPT. 2 - 1895</u>		<u>70</u> yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
<u>RETIRED CARPENTER</u>						<u>MARYLAND</u>			<u>USA</u>			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
<u>JAMES RADA</u>					<u>SOPHIA KAPTISH</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
					<u>217-09-4235</u>		<u>MRS. SARAH RADA</u>			<u>GRASONVILLE MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u>										<u>6 mos</u>		
150X												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO (b)												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>1 June, 1966</u> , to <u>5 Jan, 1966</u> , that (I) (we) last saw the deceased alive on <u>5 Jan 1966</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.												
22a. SIGNATURE <u>Stephen P. Carney</u>										22b. DATE SIGNED <u>5 Jan 66</u>		
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN P. CARNEY</u>										22d. ADDRESS <u>EASTON MARYLAND</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)				
<u>BURIAL</u>			<u>JAN. 7</u>		<u>STEVENSVILLE</u>			<u>STEVENSVILLE MD.</u>				
24. FUNERAL DIRECTOR <u>Edgard L. Lane</u>						ADDRESS <u>CHURCH HILL, MD.</u>		25a. REC'D BY REGISTRAR <u>JAN 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>TAILOT</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>6 hrs. 5 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLOYD</u> Middle <u>T</u> Last <u>RIGGIN</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>16</u> Year <u>1966</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>JULY 16, 1901</u>			9. AGE (In years last birthday) <u>64</u> yrs.			10. IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISH PEDDLER</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				
13. FATHER'S NAME <u>JOHN RIGGIN</u>						14. MOTHER'S MAIDEN NAME <u>EMMA MORRIS</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO.			17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>13 Jan</u> , 19 <u>66</u> , to <u>13 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>13 Jan</u> , 19 <u>66</u> , and that death occurred at <u>4:05 P</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Stephen P. Carney</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>18 Jan 66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>						22d. ADDRESS <u>Easton, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN. 15, 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>SHAD POINT</u>			23d. LOCATION (City, town or county) (State) <u>NEAR SALISBURY MD.</u>				
24. FUNERAL DIRECTOR <u>NORRIS MOORE</u>						ADDRESS <u>DENTON, MD.</u>			25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>				
						25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			DATE <u>JAN 18 1966</u>				

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MEMORANDUM

TO : Mr. Tolson
FROM : Mr. E. A. Tamm
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

[illegible]

[illegible signature]

13 June 1935
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u> 20-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					f. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William James Roe, Sr.</u>			First Middle Last		4. DATE OF DEATH 1/5 1966		Month Day Year		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/10/1896</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Roe</u>					14. MOTHER'S MAIDEN NAME <u>Sarah L. Frampton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>212-16-7751</u>		17. INFORMANT Address <u>Mrs. W. J. Roe, Tilghman, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>4/18-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-11, 1965</u> , to <u>12-14, 1965</u> , that (I) (we) last saw the deceased alive on <u>12-14, 1965</u> , and that death occurred at <u>12:15</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>S. KRECH, JR.</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-7-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>S. KRECH, JR.</u>					22d. ADDRESS <u>EASTON, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Sherwood, Md.</u>		
24. FUNERAL DIRECTOR <u>MAURICE E. NEUNAM & SON, Easton, Md.</u>					25a. REC'D BY REGISTRAR <u>10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> 01378 MARYLAND STATE DEPARTMENT OF HEALTH 01333 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>61 1/2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u> 20-1 d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Mr. Roland</u> First <u>Will</u> Middle <u>Seymour</u> Last 4. DATE OF DEATH Month <u>1-</u> Day <u>27</u> Year <u>1966</u>					5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>AUG 1, 1911</u> 9. AGE (In years last birthday) <u>54 yrs.</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>COMMERCIAL</u> 11. BIRTHPLACE (County & State, or foreign country) <u>ST. MICHAELS, MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>DANIEL L. SEYMOUR</u> 14. MOTHER'S MAIDEN NAME <u>ROWENA MAE JACKSON</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Mrs. Rowena Kilmon, NEW COMB MD</u> Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> <u>Dissection of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MULTIPLE</u> <u>Multiple pulmonary abscesses</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. 22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>27 Jan 66</u> 22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> 22d. ADDRESS <u>Easton, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan 29, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u> 23d. LOCATION (City, town or county) <u>St. Michaels, Md</u> (State) _____									
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>St. Michaels, Md</u> 25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>FEB 1 1966</u>									

MEDICAL CERTIFICATION

66316

TO: W

FROM: W

RE: W

DATE: 11/1/00

NAME: W

AGE: W

STREET: W

CITY: W

STATE: W

POSTAL: W

NAME: W

ADDRESS: W

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01334

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Carmichael</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>17-2</u>	
3. NAME OF DECEASED (Type or print) <u>Linwood</u>		4. DATE OF DEATH <u>18 19 66</u>	
5. SEX <u>m</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 11, 1887</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR <u>18</u> Months <u>1</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Queen Anne, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Single</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wilmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-0134</u>	
17. INFORMANT <u>Helen Freeman</u>		Address <u>Ny Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>177X</u> DUE TO <u>UREMIA</u> (b) <u>CANCER PROSTATE</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>14R.</u> <u>2YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 18</u> , 19 <u>66</u> , to <u>18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>18 JAN</u> 19 <u>66</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard F. Tyson</u>		22b. DATE SIGNED <u>1-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD F. TYSON</u>		22d. ADDRESS <u>36 S. AURORA ST., EASTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>1-22-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Carmichael Cem</u>		23d. LOCATION (City, town or county) (State) <u>Carmichael Md.</u>	
24. FUNERAL DIRECTOR <u>James B. D. ...</u>		25a. REC'D BY REGISTRAR <u>JAN 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01331

[Faint, illegible handwritten text covering the majority of the page]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01380

01335

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN ID <u>DOA @ 12pm</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30-4</u>	
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>Michael</u> Last <u>Smith</u>		d. STREET ADDRESS <u>4303 Greenhill Ave.</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md. Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Augustus Smith</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Michocki</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>Elmer A. Smith, father, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Grand Mal Seizure</u> <u>7531</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>D. F. Free Brain Damage (CEC)</u> (c) <u>Prematurity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <u>1/27/66</u>			
ACTUAL SIGNATURE <u>Harold B. Plummer</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Harold B. Plummer MD</u>		Address (Street, city, town, or county) <u>Preston Coles</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/31/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

11335

Elmer Augustus Smith, Jr.
1-10-35
to
1-10-35
Elmer A. Smith, father, above

Green Mt. Grove
D. E. Smith, Jr.
1-10-35

Elmer A. Smith, Jr.
1-10-35
Elmer A. Smith, Jr.
1-10-35

1
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04390

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL TRAPPE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MD b. COUNTY TALBOT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON d. STREET ADDRESS 133 S. WASHINGTON e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT G. SNYDER 4. DATE OF DEATH JAN 17 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH MAY 8, 1921 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor 10b. KIND OF BUSINESS OR INDUSTRY State Roads Comm. 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chester W. Snyder 14. MOTHER'S MAIDEN NAME Grace Schneider 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) World War II 16. SOCIAL SECURITY NO. 217-60-5640 17. INFORMANT Mr. William Snyder Address 5600 Loch Raven Boulevard		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DROWNING 975X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Body recovered Choptank River Mar 19, 1966 20c. TIME OF INJURY Month, Day, Year Hour a.m. Jan 17 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) Choptank R. 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED 3-19-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/21/1966 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery 23d. LOCATION (City, town or county) (State) Pikesville, Md.		24. FUNERAL DIRECTOR Wm. J. Tichner & Sons Address Baltimore, Md. 117 North Pa. Ave. 25a. REC'D BY REGISTRAR MAR 21 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

023000

1-12-51

100 = Washington

Robert C. Surber
May 3, 1951

100 = Washington

100 = Washington

Browning

Bob, the great fighter, 1941-1951

100 = Washington

X

James D. West

West, J.

X

3-1-51

100 = Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01381									
01336									
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton (rural)</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>20-1</u>				
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EARL</u> Last <u>STEVENS</u>					4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1966</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/1902</u>		9. AGE (In years last birthday) <u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Stevens</u>					14. MOTHER'S MAIDEN NAME <u>Evelyn Lyons</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>217-28-3050</u>		17. INFORMANT <u>Mrs. J. Earl Stevens, Easton, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>with angina pectoris</u> (c) <u>unknown</u>								INTERVAL BETWEEN ONSET AND DEATH <u><10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		Month, Day, Year _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on <u>D.O.A. 1-4 1966</u> , and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert W. Trever</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/6/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>		23d. LOCATION (City, town or county) (State) <u>Oxford, Md.</u>		
24. FUNERAL DIRECTOR <u>Maurice O. Newnan & Son</u>					ADDRESS <u>Easton, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1138

10/10/1908

London

London (cont)

10

10/10/1908

1138

London (cont)

London

London

London

10/10/1908

10

London

London

10/10/1908

London

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton (rural)</u> <u>20-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS <u>RFD # 1 Box 115 M</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Mitchell</u> Last <u>Terry</u>						4. DATE OF DEATH Month <u>31</u> Day <u>19</u> Year <u>66</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/11/1905</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>mechanical civil</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Little Sioux Iowa</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Bennett M. Terry</u>						14. MOTHER'S MAIDEN NAME <u>Murtle Byers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>558-07-2455</u>		17. INFORMANT <u>Mrs. Paul M. Terry, RFD #1, Easton, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> to <u>Jan</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>20 Jan</u> 19 <u>66</u> , and that death occurred at <u>10:50</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Stephen P. Carney</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-31-66</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>2/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Maurice E. Newman</u>						ADDRESS <u>501 Easton, Md</u>		25a. REC'D BY REGISTRAR <u>Feb 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
CERTIFICATE OF DEATH											
01383											
1. PLACE OF DEATH a. CDUNTY <u>TALBOT</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u> c. LENGTH OF STAY IN 1b <u>3 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u> <u>20-1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE PETERS WILLCOX</u>						4. DATE OF DEATH Month Day Year <u>JAN 1 1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 23, 1895</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER VARIETY STORES</u>		11. BIRTHPLACE (County & State, or foreign country) <u>COLUMBIANA, OHIO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>RODERICH WILLCOX</u>						14. MOTHER'S MAIDEN NAME <u>BERTHA PETERS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>275-03-8737</u>		17. INFORMANT Address <u>MRS. C.P. WILLCOX P.O. EASTON, MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>5400</u> DUE TO (b) <u>Probable peptic ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>unknown</u> DUE TO (c) <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Warfarin therapy</u> <u>Recent myocardial infarction</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>15 June</u> , 19 <u>65</u> , to <u>1 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2 Dec</u> , 19 <u>65</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Stephen P. Carney</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN P. CARNEY</u>						22d. ADDRESS <u>EASTON, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JAN 2, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEADER HILL</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u>				ADDRESS <u>Easton Md</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01384						01339					
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston R.F.D. (Jonestown)</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS <u>R.F.D. # 2- Box 102</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>GLORIA</u> Middle <u>LUCRETIA</u> Last <u>WILSON</u>			4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1966</u>			5. SEX <u>Fe</u>			6. COLOR OR RACE <u>Col.</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-2-66</u>			9. AGE (In years last birthday) <u>3</u> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Talbot county, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Robert Wilson</u>		
14. MOTHER'S MAIDEN NAME <u>Lucretia Rose Jackson</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Infant</u>			17. INFORMANT <u>Mrs. Lucretia J. Wilson, Preston, Md. R.F.D.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> <u>7620</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intra uterine anoxia</u> DUE TO (c) <u>Prolonged labor - dystocia</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-2</u> , 19 <u>66</u> , to <u>1-5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-5</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>R. H. Trapnell</u>						22b. DATE SIGNED <u>1-11-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>R. H. Trapnell, M.D.</u>						22d. ADDRESS <u>Federalburg, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church of God in Christ Cem. Preston, Md. R.F.D.</u>				23d. LOCATION (City, town or county) (State) <u>Preston, Md. R.F.D.</u>	
24. FUNERAL DIRECTOR <u>Wm. Thompson Jr. Federalburg, Md.</u>						25a. REC'D BY REGISTRAR <u>1-17-1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01385					01340				
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u> <u>17-2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>Box 61</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willis</u>			First Middle Last <u>Worley</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robin Worley</u>				14. MOTHER'S MAIDEN NAME <u>Jalie Byrd</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-16-7849</u>		17. INFORMANT <u>Charles Taylor</u>		Address <u>Church Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis</u> <u>466 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>thrombosis pelvic veins</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>11:20</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>E.C.H. Schmidt</u>				M.D. ATTENDING PHYS. <u>Easton, Maryland</u>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>20/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burrsville Cem</u>		23d. LOCATION (City, town or county) (State) <u>Church Hill Md.</u>			
24. FUNERAL DIRECTOR <u>James B Dashiell Easton Md</u>				25a. REC'D BY REGISTRAR <u>JAN 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY TALBOT		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY QUEEN ANNES	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Centreville		d. STREET ADDRESS Waltham Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FANNY Middle EARLE Last WRIGHT		4. DATE OF DEATH Month JANUARY Day 8 Year 1966		5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 20, 1873		9. AGE (In years last birthday) 92 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Centreville, D.A. Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Brundige Earle		14. MOTHER'S MAIDEN NAME Louisa Stubbs		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 226-46-0378	
17. INFORMANT Mrs. Frances W. Hilleary		Address Waltham Farm, Centreville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1-3-66		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of rt. femur	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 11:35 M, from the causes and on the date stated above.		22a. SIGNATURE Robert W. Trever		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Robert W. Trever, M.D.	
22d. ADDRESS Easton, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Family Cemetery - Melfield		23d. LOCATION (City, town or county) (State) Centreville, D.A. Co. Md.	
24. FUNERAL DIRECTOR James W. Butler		25a. REC'D BY REGISTRAR DATA 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. REGISTRAR'S NAME James W. Butler		25d. REGISTRAR'S ADDRESS Centreville, Md.	

Robert W. Traver, R.D. 1, Madison, Wisconsin